i. In conjunction with the attending physician and supervisory RN, the QMRP will assist in the development of the plan of care for the recipient for those aspects of active treatment which are provided in the home by the PCS attendant. (1-1-91)

ii. Review of the care and/or training given by the personal care provider through a review of the recipient's PCS record as maintained by the provider, and on-site interviews with the client at least every ninety (90) days. (1-1-91)

iii. Reevaluation of the plan of care as necessary, but at least annually. (1-1-91)

iv. An on-site visit to the recipient to evaluate any change of condition when requested by the PCS provider, provider agency, nurse supervisor, case manager, or recipient. (1-1-91)

06. PCS Provider Qualifications. (1-1-91)

a. Persons providing PCS: Individuals may provide PCS either as PCS agency employees or as independent providers if they have at least one (1) of the following qualifications: (1-1-91)

i. Registered Nurse, RN: A person currently licensed by the Idaho State Board of Nursing as a registered nurse; or (7-15-83)

ii. Licensed Practical Nurse, L.P.N.: A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; or (7-15-83)

iii. Nursing Assistant: All nursing assistants who provide PCS to eligible individuals must appear on the Idaho State Board of Nursing's registry of certificated nurse aides (CNA). An individual who has completed a certified nurse aide training program may be granted provisional provider status for up to ninety (90) days by the Department to allow for the completion of competency testing and registry. (1-30-94)

b. All persons who care for developmentally disabled clients other than those with only physical disabilities as identified by the Department's RMU will, in addition to the completion of the requirements of Subsection 146.06.a.iii., have completed one (1) of the Department approved developmental disabilities training courses. Providers who are qualified as QMRPs will be exempted from the Department approved developmental disabilities training course. Each region may grant temporary approval to an individual who meets all qualifications except for the required developmental disabilities training course to become a PCS provider to a developmentally disabled recipient if all of the following conditions are met: (7-1-94)

i. The RMU has verified that there are no qualified providers reasonably available to provide services to client requesting services; and (7-1-94)

ii. The provider must be enrolled in the next available training course with a graduation date no later than six (6) months from the date of the request for temporary status; and (7-1-94)

iii. The supervising QMRP makes monthly visits until the provider graduates from the training program. (7-1-94)

c. Agency providers must submit to the Department documentation of their worker's compensation and professional liability insurance coverage. In the case of worker's compensation, agencies will direct their sureties to provide a certificate of insurance to the Department. Independent providers must submit to the Department documentation of their professional liability insurance coverage. Termination of either type of insurance by the provider will be cause for termination of PCS Provider status by the Department. Agency

providers will keep copies of employee health screens in their files for review by the Department as necessary. Independent providers will submit the completed health screen to the Department. Agency and independent providers will complete a criminal history check conducted by the Department. If no criminal history is indicated on the Self-Declaration form, individuals may be authorized by the Region to provide services on a provisional basis while awaiting the results of the fingerprinting process. Such authorization may be provided after the client's safety is assured by the responsible Region. (1-30-94)

d. Individuals providing supervision to PCS attendants. (1-1-91)

i. RN supervisors will have a current Idaho Professional nursing license (RN). (1-1-91)

ii. QualifiedMentalRetardationProfessional (QMRP) supervisors will be qualified by education and training as required in 42 CFR 483.430. (1-1-91)

iii. Supervising RNs and QMRPs who are independent providers will be independent contractors and obtain any desired benefits such as life, disability and/or unemployment insurance that he may desire, maintain professional liability insurance, and report all income to the appropriate authorities, pay social security and all other state and federal taxes. (1-1-91)

e. Provider agency. An entity which has a signed provider agreement with the Department and is capable of and responsible for all of the following: (1-1-91)

i. Recruitment, hiring, firing, training, supervision, scheduling and payroll for personal care attendants and the assurance of quality service provided by the personal care attendants; and (1-1-91)

ii. Participation in the provision of worker's compensation, unemployment compensation and all other state and federal tax withholdings; and (8-5-91)

iii. Maintenance of liability insurance coverage; and (1-1-91)

iv. Provision of a licensed professional nurse (RN) and, where applicable, a QMRP supervisor to develop and complete plans of care and provide ongoing supervision of a recipient's care; and (1-1-91)

v. Assignment of a qualified personal care attendant(s) to eligible recipients after consultation with and approval of such recipients; and (1-1-91)

vi. Assure that all PCS attendants meet the qualifications in Subsection 146.06.a.; and (12-31-91)

vii. Billing Medicaid for services approved and authorized by the RMU; and (1-1-91)

viii. Make referrals for PCS eligible recipients for case management services when a need for such services is identified; and (1-1-91)

ix. Conduct such criminal background checks and health screens on new and existing employees as required in Subsection 146.10. and 146.11. (12-31-91)

f. Independent providers. Persons who meet the training requirements in Subsection 146.06.a. and will: (12-31-91)

i. Obtain the required training, certifications, agreements, knowledge and information needed to function as an independent provider; and (1-1-91)

ii. Obtain any desired benefits such as life, disability and/or unemployment insurance that he may desire; and (1-1-91)

iii. Maintain professional liability insurance effective April 15, 1991, for certified nurse's aides, and upon completion of the certified nurse's aide course for all other providers; and (7-1-94)

iv. Report all income to the appropriate authorities, pay social security and all other state and federal taxes as an independent contractor; and (1-1-91)

v. Submit claims to the Medicaid Program for approved services; and (1-1-91)

vi. Provide for care by a fully trained and qualified replacement when unable to provide service; and (1-1-91)

vii. Provide unanticipated services that are not part of the plan of care in emergency situations; and (1-1-91)

viii. Participate in the background check and obtain the health screen required in Subsection 146.10. and 146.11.; and (12-31-91)

ix. When care is provided in the provider's home, acquire the appropriate level of foster care licensure or certification. The provider must be licensed as a Level I or Level II children's foster home as defined in Section 39-1209, Idaho Code, for care of individuals under eighteen (18) years of age. For care of individuals eighteen (18) years of age or older, the provider must meet the environmental sanitation standards, fire and life safety standards, and building, construction and physical home standards for certification as an Adult Foster Home. Noncompliance with the above standards will be cause for termination of the provider's provider agreement. (10-01-94)T

g. Utilization of independent providers. Independent providers will be utilized in the following circumstances: (8-5-91)

i. When a provider agency is unavailable; or (8-5-91)

ii. When, based on an assessment involving the recipient, the recipient's family and the Department's regional Medicaid staff, it is determined that an independent provider will best meet the needs of the recipient. The assessment shall include consideration of the recipient's and/or family member's ability to select a provider and manage and evaluate the care he receives. (8-5-91)

iii. Recipients receiving PCS from an independent provider should be evaluated for the need for targeted case management from a provider agency or administrative case management from the Department. (1-1-91)

iv. The independent provider will not be considered an employee of the state, recipient, or RN supervisor, but will be considered an independent contractor. (1-1-91)

h. A PCS provider cannot be a relative of any recipient to whom the provider is supplying services. (5-1-87)

i. For the purposes of this subsection, a relative is defined as a spouse or a parent of a minor child. (1-1-91)

ii. Nothing in this subsection shall be construed to prohibit a relative from providing PCS where Medicaid is not the payment source for such services. (1-1-91)

07. Recipient Eligibility Determination. An eligible recipient may qualify for PCS coverage either under the Idaho State Medicaid Plan or the

Department's Home and Community Based Services waiver. For both programs, the recipient must be financially eligible for MA as described in Idaho Department of Health and Welfare Rules, Title 3, Chapter 5, "Eligibility for the Aged, Blind and Disabled (AABD)." The cited chapter implements and is in accordance with the Financial Eligibility Section of the Idaho State Plan. In addition, waiver recipients must meet the following requirements: (12-31-91)

a. The Department's Regional Medicaid Unit must determine that: (1-1-91)

i. The recipient would qualify for nursing facility level of care as set forth in Manual Subsections 03.09.180.03. and 180.08 if PCS were not made available; and (1-1-95)T

ii. In the assessment of the RMU the patient could be maintained in their own home or residence and receive safe and effective services through the Personal Care Service Program; and (1-1-91)

iii. In the assessment of the RMU, the average monthly Medicaid cost of providing Personal Care Services and other community services to the patient would not exceed the average Medicaid cost of nursing facility care as described below: (7-1-94)

(a) The average monthly Medicaid cost of personal care and other medical services paid by Medicaid will be calculated utilizing the number of visits or hours or days of PCS and medical services prescribed by the attending physician for the patient. (1-1-91)

(b) The average monthly Medicaid patient cost of nursing facility care will be calculated by the Bureau of Medicaid Policy and Reimbursement utilizing projected Medicaid Program expenditures for institutional care, based on the average interim rate for that type of care. (1-1-95)T

(c) If the amount identified in Subsection 146.07.a.iii.(a) is less than the amount identified in Subsection 146.07.a.iii.(b) then the individual is eligible for PCS. (1-30-94)

(d) If the amount identified in Subsection 146.07.a.iii.(a) is greater than or equal to the amount identified in Subsection 146.07.a.iii.(b) then the individual is not eligible for PCS. (12-31-91)

(e) Eligible recipients receiving PCS under the Idaho State Plan must have medical justification, physician's orders, and plan of care for such services. All services will be authorized by the RMU prior to payment for the amount and duration of services. (1-1-91)

iv. Following the approval by the RMU for services under the waiver, the recipient must receive and continue to receive a waiver service. For the purposes of these rules, a waiver service is defined as personal care services in excess of sixteen (16) hours per week. A recipient who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (1-1-91)

b. A recipient who is determined by the Department to be eligible for the Personal Care Services Program under the Home and Community Based Services waiver may elect not to utilize PCS, but may choose admission to a nursing facility. (7-1-94)

c. The recipient's eligibility examiner will process the application in accordance with Idaho Department of Health and Welfare Rules, Title 3, Chapter 5, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," as if the application was for admission to a nursing facility, except that the eligibility examiner will forward potentially eligible applications immediately to the RMU for review together with the physician's prescription for Personal Care Services. The Medicaid application process cited above con-

forms to all statutory and regulatory requirements relating to the Medicaid application process. (12-31-91)

d. The decisions of the RMU regarding the acceptance of the recipients into the PCS program will be transmitted to the eligibility examiner. The eligibility examiner will notify the applicant of the Department's determination in accordance with Idaho Department of Health and Welfare Rules, Title 3, Chapter 5, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," except: (10-1-94)T

i. The referring physician will be notified, in addition to the applicant, of the determination; and (7-15-83)

ii. If the application is approved, the RMU will provide a list of personal care providers to the client, or their representatives, to select the provider of their choice. (1-30-94)

08. Case Redetermination. (12-31-91)

a. Financial redetermination will be conducted pursuant to Idaho Department of Health and Welfare Rules, Title 3, Chapter 1, "Rules Governing Eligibility for Aid to Families with Dependent Children (AFDC)," and Title 3, Chapter 5, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)." Medical redetermination will be made at least annually by the RMU, or sooner at the request of the patient, the eligibility examiner, PCS provider agency, independent personal care provider, the supervising registered nurse, or the physician. The sections cited implement and are in accordance with Idaho's approved state plan with the exception of deeming of income provisions. (1-30-94)

b. The redetermination process will assess the following factors: (7-15-83)

i. The recipient's continued need for the Personal Care Services Program; and (7-15-83)

ii. Discharge from the Personal Care Services Program; and (7-15-83)

iii. Referral of the patient from the Personal Care Services Program to a nursing facility or licensed residential care facility. (7-1-94)

09. Criminal History Check. All personal care providers (case managers, RN supervisors, QMRP supervisors and personal care attendants) shall participate in a criminal history check as required by Section 39-5604, Idaho Code. The criminal history check will be conducted in accordance with Title 3, Chapter 18, "Rules Governing Mandatory Criminal History Checks". (10-1-94)T

10. Health Screen. The Department will require that a health questionnaire be completed by each independent provider and provider agency employee who serves as a personal care attendant. Provider agencies will retain this in their personnel file. Independent providers will complete the questionnaires as part of the application. If the applicant indicates on the questionnaire that he has a medical problem, the individual will be required to submit a statement from a physician that his medical condition would not prevent him from performing all the duties required of a personal care provider. Misrepresentation of information submitted on the health screen is cause for termination of provider status for independent PCS providers or termination of employment for agency employees. (1-1-91)

11. PCS Record. Three types of record information will be maintained on all recipients receiving PCS and are considered to be the PCS record. (1-1-91)

c. As approved by the Director or his designee. (7-15-83)

15. Home and Community-Based Waiver Recipient Limitations. The number of unduplicated count Medicaid recipients to receive personal care services under the home and community-based waiver will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for personal care services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30, of each new waiver year. The earliest effective date of personal care services service delivery for these clients will be October 1 of each new waiver year. (10-1-94)T

16. Community Awareness Program. The Department will establish a community awareness program that will educate Idaho citizens regarding the purpose and function of all long-term care alternatives including, but not limited to, personal care services and individual recipient rights. This program will be developed in cooperation with other state agencies including, but not limited to, theOfficeOnAging and theDivision ofVocationalRehabilitation. (10-1-94)T

147. (RESERVED).

148. PROVIDER REIMBURSEMENT FOR PERSONAL CARE SERVICES. (10-1-94)T

01. Reimbursement Rate. Personal care providers will be paid a uniform reimbursement rate for service as established by the Department pursuant to Section 39-5606, Idaho Code, on an annual basis. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (1-1-91)

02. Calculated Fee. The fee calculated for personal care provider reimbursement includes a basic rate for services and mileage. No separate charges for mileage will be paid by the Department for nonmedical client transportation or provider transportation to and from the recipient's home. Fees will be calculated as follows: (1-1-91)

a. Annually the Bureau of Medicaid Policy and Reimbursement will conduct a poll of all Idaho nursing facilities and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, QMRP, and Nurse's aide) in Idaho to be used for the reimbursement rate to be effective on July 1 of that year. (1-30-94)

b. The Bureau of Medicaid Policy and Reimbursement will then establish three (3) payment levels for both provider agencies and independent providers for PCS attendant services as follows: (1-30-94)

i. Weekly service needs of 0-16 hours or waiver recipients 0-8 hours/day:

Provider agencies:
WAHR x 1.55 = $ amount/hour

Independent providers:
WAHR x 1.22 (which is a supplemental component to cover training, social security and liability insurance)

= $ amount/hour (1-30-94)

ii. Extended visit, one (1) recipient (eight and one-quarter hour (8.25) up to twenty-four (24) hours):

Provider agencies:
(WAHR x actual hours of care up to 5 hours x 1.55)
plus ($.65 x 1.55 hours on site on-call) = $ amount
(Maximum $48.51)

Independent providers:
(WAHR x actual hours of care up to 5 hours x 1.22)
plus ($.65 x 1.22 x actual hours on site on-call) =
$ amount (Maximum $46.00) (1-30-94)

iii. Extended visit, two (2) recipients (six and one-quarter (6.25) up to twenty-four (24) hours):

Provider agencies:
(WAHR x actual hours of care up to 4 hours) x (1.55
plus $.65 x 1.55 x hours on site on-call) = $ amount
(Maximum $41.36)

Independent providers:
(WAHR x hours actual care up to 4 hours x 1.22) plus
($.65 x 1.22 x hours on site on-call) = $ amount
(Maximum $33.79) (1-30-94)

c. The attending physician will be reimbursed for services provided using current payment levels and methodologies for other physician services provided to eligible recipients. (1-1-91)

d. The supervisory RN and QMRP will be reimbursed at a per visit amount established by the Department for supervisory visits. Client evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the RMU. (1-1-91)

i. The number of supervisory visits by the RN and QMRP to be conducted per calendar quarter will be approved as part of the PCS care plan by the RMU. (1-1-91)

ii. Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the RMU. (1-1-91)

149. CLIENT PARTICIPATION IN THE COST OF WAIVER SERVICES. A recipient will not be required to participate in the cost of PCS unless his entitlement to MA is based on his approval for and receipt of a waiver service and income limitations contained in Idaho Department of Health and Welfare Rules, Title 03, Chapter 05, Section634., "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)." Income excluded under the provisions of Idaho Department of Health and Welfare Rules, Title 03, Chapter 05, Sections613. and 615., "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," is excluded in determining client participation. (10-1-94)T

01. Definitions. The following definitions apply to determining client participation: (1-29-90)

a. Community Spouse. The spouse of an HCBS recipient who is not an HCBS client and is not institutionalized. (7-1-93)

b. Community Spouse Allowance (CSA). The maximum amount deducted from a recipient's income for support of his community spouse. (1-29-90)

c. Community Spouse Need Standard (CSNS). The total income the community spouse needs for his support. This amount must not exceed one thousand eight hundred and sixteen dollars ($1,816). (10-1-94)T

02. Individual With No Community Spouse. The amount of client participation for an individual who is not exempt from the client participation requirement and who has no community spouse is determined by deducting certain amounts from the client's income, after the AABD income exclusions are deducted. A veteran with no spouse or other dependents or the surviving spouse of a veteran with no dependents receives a protected VA pension, which amount will not be counted as income for client participation. This protected amount is ninety dollars ($90). The following amounts are deducted in the following order from the individual's own income, including income disregarded in determining his MA eligibility: (7-1-93)

a. First, the individual's AABD standard of need determined as though he were living alone in his own home. In the case of an individual in room and board or adult foster care, use the maximum special needs allowance as specified in Idaho Department of Health and Welfare Rules, Title 03, Chapter 05, Sections 407 and 408. "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD);" and (7-1-93)

b. Second, an employed client or client engaged in sheltered workshop or activity center activities, is also budgeted the lower of an additional personal needs deduction of eighty ($80) or his earned income. The client's total personal needs allowance must not exceed the sum of his AABD standard of need plus up to eighty ($80). This is a deduction only. No actual payment can be made to provide for personal needs. (7-1-94)

c. Third, a Family Member Allowance (FMA) for each family member. A family member is a person who is, or could be claimed on the client's federal income tax and who is the client's minor or dependent child, dependent sibling, or dependent parent who lives in the client's home. The FMA is computed by deducting the family member's gross income from one thousand two hundred and thirty ($1,230) and dividing the result by three (3). Any remainder with cents is rounded to the next higher dollar and is the FMA for that family member; and (10-1-94)T

i. The family member's gross income is used. (7-1-93)

ii. The FMA is deducted from the client's income whether or not it is actually contributed by the client. (7-1-93)

iii. If the client contributes an amount less than the FMA, only the actual amount contributed is deducted. If more, only the FMA is deducted. (7-1-93)

d. Fourth, amounts for the individual's incurred expenses for Medicare and other health insurance premiums, deductibles or coinsurance charges not paid by a third party. (6-1-91)

i. Deduction of incurred expenses for the Medicare Part B premium is limited to the first two (2) months of Medicaid eligibility. If the individual received SSI or an AABD payment for the month prior to the month for which client participation is being calculated, Medicare Part B premiums must not be deducted. (6-1-91)

ii. The client must report such expenses to the field office and provide verification in order for an expense to be considered for deduction. (6-1-91)

e. Fifth, amounts incurred for certain limited medical or remedial services not covered by the State's Medicaid Plan and not paid by a third party. (6-1-86)

i. The Department must determine whether an individual's incurred expenses for such limited services meet the criteria for deduction. (1-1-91)

ii. The client must report such expenses to the RMU and provide verification in order for an expense to be considered for deduction. (1-1-91)

iii. Deductions for necessary medical or remedial expenses approved by the Department will be applied at the time of application, and as necessary, based on changes reported to the field office by the recipient. (6-1-86)

03. Individual With Community Spouse. After income of the HCBS spouse and the community spouse has been attributed according to the provisions of Idaho Department of Health and Welfare Rules, Title 03, Chapter 05, Section615., "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," the amount of client participation for an individual who is not exempt from the participation requirement is determined. Income excluded under AABD is not counted. Income disregarded under AABD is counted. Deduct the following amounts in the following order from the income attributed to the recipient: (10-1-94)T

a. First, a personal need allowance of thirty dollars ($30). A client who is unable to live with his community spouse because of his medical condition or other similar circumstances beyond his control is allowed a personal needs standard equal to the AABD payment standard he would be budgeted for his living situation, if he was an AABD client. An employed client or a client engaged in sheltered workshop or work activity center activities is also allowed the lower of eighty dollars ($80) or his earned income, for his personal needs. The total personal needs allowance must not exceed one hundred ten dollars ($110); and (7-1-93)

b. Second, the Community Spouse Allowance (CSA). The CSA is determined by: (1-29-90)

i. Computing the Shelter Adjustment by subtracting three hundred sixty-nine ($369) dollars from the sum of total shelter costs (rent, mortgage principal and interest, homeowner's taxes, insurance, condominium or cooperative maintenance charges) and the Standard Utility Allowance of one hundred and sixty-two ($162). The Standard Utility Allowance is reduced by the value of any utilities which are included in maintenance charges for a condominium or cooperative. The Shelter Adjustment equals the positive balance remaining from the calculation in Subsection 146.12.c.ii.(a). ()(10-1-94)T

ii. Computing the Community Spouse Needs (CSN) by adding one thousand two hundred and thirty ($1,230) dollars to the Shelter Adjustment. The total CSNS, effective January, 1, 1994, may not exceed the maximum of one thousand eight hundred and sixteen dollars and fifty cents ($1,816.50). If a hearing or court order establishes that the community spouse needs a larger amount of income than established above, such amount will not be subject to the maximum. (10-1-94)T

iii. Computing the Community Spouse Allowance (CSA) by subtracting the community spouse's gross income from the CSNS and rounding any remaining cents to the next higher dollar. Any positive balance remaining is the CSA except if a court orders the institutional spouse to contribute a larger amount for the support of the community spouse, then the amount of support ordered by the court will be used instead of the CSA. Any amount ordered by a court will not be subject to the limit on the CSNS. The CSA will only be deducted to the extent contributed by the institutional spouse. If the institutional spouse contributes an amount less than the CSA, only the actual amount contributed will be deducted from the institutional spouse's gross income. (7-1-93)

c. Third, a Family Member Allowance (FMA) for each family member. A family member is defined as a person who is, or could be, claimed as a dependent on either spouse's federal income tax and who is a minor or dependent

child, or dependent sibling or dependent parent of either spouse who lives in the community spouse's home. The FMA is computed by deducting the family member's gross income from one thousand two hundred and thirty dollars ($1,230) and dividing the result by three (3). Any remainder with cents rounded to the next higher dollar is the FMA for that family member. (7-1-94)

i. The family member's gross income is used. (1-29-90)

ii. The FMA is to be deducted from the institutional spouse's income whether or not it is actually contributed by the institutional spouse. (7-1-93)

iii. If the institutional spouse contributes an amount less than the FMA, only the actual amount contributed is deducted from the institutional spouse's gross income. If more, only the FMA is deducted. (7-1-93)

d. Fourth, the amounts for incurred expenses for Medicare and other health insurance premiums, deductibles or coinsurance charges not subject to payment by a third party. (6-1-91)

i. Deduction of incurred expenses for the Medicare Part B premium is limited to the first two (2) months of Medicaid eligibility. If the individual received SSI or an AABD payment for the month prior to the month for which client participation is being calculated, Medicare Part B premiums must not be deducted. (6-1-91)

ii. The client must report such expenses to the field office and provide verification in order for an expense to be considered for deduction. (6-1-91)

e. Fifth, amounts incurred for certain limited medical or remedial services not covered by the State Medicaid Plan and not paid by a third party. (1-29-90)

i. The Department's Regional Medicaid Units must determine whether an individual's incurred expenses for such limited services meet the criteria for deduction. (1-1-91)

ii. The client must report such expenses to the RMU and provide verification in order for an expense to be considered for deduction. (1-1-91)

iii. Deductions for necessary medical or remedial expenses approved by the Department will be applied at the time of application, and as necessary, based on changes reported to the field office by the recipient. (1-29-90)

04. Remainder After Calculation. Any remainder after the calculation in Subsection 146.10.b. or c., whichever is appropriate, is to be deducted from the recipient's provider payments to offset the cost of personal care services. The contribution will be collected from the recipient by the provider agency or independent provider. The provider and the recipient will be notified of the amount to be collected. (12-31-91)

05. Recalculation of Client Participation Amount. The client participation amount is to be recalculated annually at redetermination or whenever a change in income or deductions is reported to the field office by the recipient. (1-1-91)

150. TRANSPORTATION. "Transportation" includes expenses for transportation, cost of meals and lodging en route to and from medical care and while receiving medical care. It also includes the cost of an attendant to accompany the recipient, if necessary, and the cost of the attendant's transportation, meals, lodging and, if the attendant is not a member of the recipient's family, salary. Preapproval of all "transportation" is required to insure that only necessary and reasonable expenses are paid. An exception to preapproval